Division of Public Health
Purchase of Medical Care Services

Pharmacy Billing Guide

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Contact Us

DHHS
Purchase of Medical Care Services
1904 Mail Service Center
Raleigh, NC, 27699-1904

Eligibility/Authorization Inquiries
919-855-3701
Claims Inquiries
919-855-3702

POMCS Unit Supervisor
919-855-3650

POMCS Claims Supervisor
919-855-3653

POMCS Authorization Supervisor
919-855-3652

POMCS Provider Relations Supervisor
919-855-3651

POMCS Website:
http://www.ncdhhs.gov/control/pomcs/pomcs.htm

This guide has been prepared to assist pharmacy providers in billing the following Purchase of Medical Care Services (POMCS) fee for service payment programs.

Adult Cystic Fibrosis Program
Children's Special Health Services (CSHS)
Kidney Program
Migrant Health Program
Sickle Cell Program

ADULT CYSTIC FIBROSIS PROGRAM

- Reimburses for durable medical equipment (DME), oral formula, condition-related over-the-counter (OTC) drugs and supplies.

CHILDREN SPECIAL HEALTH SERVICES (CSHS)

- Medicaid eligible children: CSHS reimburses for DME, oral formula, condition-related OTC drugs and supplies.
- Children not eligible for Medicaid: With post-adoption coverage, CSHS reimburses for prescription drugs, DME, oral formula, condition-related OTC drugs and supplies.
- CSHS will reimburse for authorized DME and supplies. Please refer to the DME, Supplies and Oral Formula billing guide.

KIDNEY PROGRAM

- The program payments are limited to $300.00 per patient per fiscal year (July 1 - June 30).
- The program reimburses for condition-related drugs and supplies on the covered list, Guidance for Payment of Kidney Program Pharmacy Claims.
- Keep a record of the total amount received to assist in

monitoring the yearly payment limit.

- Do not assume former patients will remain eligible; inquire about the patient's authorization if you do not have it.
- The program does not require prescriptions for OTC items; the "reference number" column on the claim form does not require a prescription number.

MIGRANT HEALTH PROGRAM

- Migrant Health Program reimburses for prescribed drugs, OTC drugs and supplies included on the Migrant Health Formulary.
- The allowable patient co-payment is $6.00 for each prescribed drug and supply and $5.00 per claim, per date of service for all other services

SICKLE CELL PROGRAM

- Sickle Cell Program covers medications listed on the program formulary
- Erythropoietin (Epogen/Procrit) requires approval through a special application process.

POMCS Requirements

Step 1: Financial Eligibility Determination

- Clients must complete a financial eligibility application with a financial interviewer to assess their ability to pay for medical care using program guidelines and income scales.

- For the Migrant program the DHHS Form 3753 must be completed and sent by an interviewer from one of the designated Migrant Health Entry Points. The Migrant Health Program requires that this form be completed rather than a Financial Eligibility Application (DHHS Form 3014).

Step 2: Authorization of Service

- Requested services must be authorized before payment can be made, except in the Migrant Health Program.
- Authorization Request (DHHS Form 3056) must be submitted to Purchase of Medical Care Services within 1 year after the date of service and must be signed by a physician.
- Authorization Requests will be approved, denied, or placed in pending status for additional information within 45 days after their receipt date. If additional information is requested it must be received within one year after the date of service or within 30 days after we request the additional information, which ever is later. If it is not received within that time the Authorization Request will be denied.
- Providers will receive a Reply to Authorization Request explaining if the service was approved or denied or requires additional information. If additional information is needed to process the request providers may receive a Request for Additional Information form instead.
- In the Migrant Health Program, a current approved Eligibility Application (DHHS Form 3753) must be on file with Purchase

of Medical Care Services before a claim can be paid.
- Pharmacy changes must be authorized before payment can be made to a new pharmacy.

Step 3: Claims
Claims for authorized services must be received by POMCS within 1 year after the date of service or within 45 days after the service was approved, whichever is later.

Claim Forms
- **Pharmacy Claim Form DHHS 3058 -** A revised pharmacy claim form is available upon request or on the website and should be used for billing legend drugs and OTC drugs. Use of the revised form will be mandatory effective 01/01/07. Please note the following are required items:
    - Identify drug as brand or generic
    - Dispensing fee for brand or generic drug
- **HCFA/CMS 1500 –** Use to bill DME, medical supplies, oral formula having HCPCS codes and OTC drugs. A list for HCPC codes is available upon request. When billing OTC drugs using this form, write “No Code” in the procedure code column. Please refer to the DME, Supplies and Oral Formula billing guide.

Claims Requirements
- Claims must be received within one year after the dispensing date.
- Chain stores should include individual store numbers along with addresses.
- Enter last name, first name and middle initial, in that order on the claim form.
- Include the client’s date of birth to the right of his/her name on the form.
- Write the program name, Medicaid provider number and patient’s case and authorization number on the claim in the spaces provided.

Reimbursement
- **Drugs** – Prescription drugs are paid at the Medicaid rate plus a dispensing fee (one fee per prescription drug per month). The dispensing fee must be billed to be paid. When the physician has written "Dispense as Written" in his handwriting on a prescription, the override "OA" should be entered on the claim form in the last two digits of the NDC number.

- **Formularies** - All POMCS program formularies are subject to change.

- **Medicaid co-payments** - DHHS programs do not pay the Medicaid co-payment or in any other way supplement Medicaid payments on Medicaid eligible patients.

- **DME, Medical Supplies, and Oral Formula** – These are also reimbursed at the Medicaid rate based on the item's HCPCS procedure code. Items for which there are no Medicaid rates are paid at the usual charge to the general

public. A sales tax charge may not be added for prescription drugs or for equipment and supply items paid according to Medicaid code. The Medicaid rate is inclusive of tax and freight.

- **Response time to claims** - The DHHS will make payment for an authorized service or provide a response within 45 days after receipt of a correctly completed claim.

- **Billing patient prohibited** - Providers may not bill the patient for any drug for which they have accepted partial or total payment from the program. Patients may only be billed for items for which the provider does not accept program payment. If a provider receives a third party payment after the program has paid, they must refund the lesser of the two amounts to the program.

Medicaid Eligible Clients

- **DHHS programs will not cover services that should be covered by Medicaid.** Claims for services covered by Medicaid must be billed directly to Medicaid. If Medicaid pays the claim after DHHS has made payment, the full DHHS payment should be returned to DHHS. **Note:** Children's Special Health Services will accept claims for authorized durable medical equipment and certain supplies if the patient has Medicaid. Claims for diabetic supplies, tracheostomy supplies, enteral formula, equipment or supplies used to administer enteral formula and supplies on the Medicaid home health fee schedule must be billed directly to Medicaid.

- **Retroactive Medicaid coverage** - If the patient receives retroactive Medicaid coverage for dates of service paid by DHHS, the provider must bill Medicaid and return the DHHS payment.

Refunds

- If another third party payor pays the claim after DHHS has made payment, the lesser of the two payments should be returned to DHHS.
- Refunds should identify the patient, program, case and authorization numbers.

Refunds of DHHS Payments

Refunds
Purchase of Medical Care Services
1904 Mail Service Center
Raleigh, NC 27699-1904

State of North Carolina
Michael F. Easley, Governor
North Carolina Department of Health and Human Services
Carmen Hooker Odom, Secretary